

Medical Records Request Instructions

NOTE: Medical Records Request form MUST be filled out and signed!

Once the form is complete and signed, you may use the following options to return the form:

1. Send by **mail to:** 1665 Dominican Way, Suite 222, Santa Cruz, CA 95065
Attn: Medical Records Dept.

2. Fax to: (866) 264-3890

3. Drop Off Locations:

**Santa Cruz:*

1665 Dominican Way #222, Santa Cruz, CA 95065

**WATSONVILLE:*

150 Carnation Drive #4, Freedom, CA 95019

**LOS GATOS:*

777 Knowles Drive #15, Los Gatos, CA 95032

**SUNNYVALE*

260 S. Sunnyvale Avenue #6, Sunnyvale, CA 94086

If you have any questions or concerns please call (844) 387-5337 x 105.



Authorization for Release of Medical Information

This form will be used to obtain medical records from another provider to Sleep Health MD

Patient's Name: _____

Date of Birth: _____

I hereby authorize Sleep Health MD to obtain my protected health information (PHI) as defined by Federal and State law. I understand that this authorization is voluntary.

The following information may be disclosed to Sleep Health MD:

- Medical Records
- Test Results
- Sleep Studies
- Other

*

The following section must be completed in full in order to obtain medical records

This Health Information may be disclosed by:

Name of the Provider: _____

Address: _____

Phone: _____ Fax: _____

I understand that my health care will not be affected if I do not sign this form. This authorization will expire on _____ or 5 years from the date of my signature below, whichever is earlier.

I also understand that I may revoke this authorization at any time by notifying Sleep Health MD in writing. I understand that my revocation of this authorization will not affect any actions taken by Sleep Health MD in reliance on this authorization prior to the time it received my revocation.

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient (to the extent minor could not have consented to the care).
- Guardian or conservator of an incompetent patient.
- Beneficiary or personal representative of deceased patient.

web: www.sleephealthmd.com phone: 844-387-5337 fax: 866-264-3890

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